

FAMILY PRACTICE

HISTORY AND PHYSICAL

Name _____

Age: _____

Date _____

DRUG ALLERGIES

FAMILY HISTORY

CURRENT MEDS

	Father	Mother	Mother's Parents	Father's Parents	Siblings	Children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy / Convulsions						
Bleeding disorder						
Kidney disease						

HOSPITALIZATION OR SURGERY

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Tetanus _____ | <input type="checkbox"/> Allergies / Hay fever _____ | <input type="checkbox"/> Shortness of Breath _____ |
| <input type="checkbox"/> Diphtheria _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart palpitations _____ |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Rash _____ | <input type="checkbox"/> Heart murmur _____ |
| <input type="checkbox"/> Rubella _____ | <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Chest Pain _____ |
| <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Gall bladder disease _____ | <input type="checkbox"/> Dizziness / Fainting _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Sexual / Menstrual dysfunction _____ | <input type="checkbox"/> Heart Attack _____ |
| <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Cholesterol _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Scarlet fever _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> _____ |

HABITS

- Smoke: Packs daily _____ How long _____ When stopped _____
- Exercise routine _____ Seat Belt _____ Alcohol: Type / Amount _____

FEMALES ONLY

- Pregnant? Yes NO Planning Pregnancy Yes No
- Last Menstrual Period _____ How Many Pregnancies _____
- Last Pap Smear _____ Normal or Abnormal (Circle)
- Last Mamogram _____ Normal or Abnormal (Circle)

REVIEW OF SYSTEMS

Neurological

Cerebrovascular

GU

Dermatologic

Peripheral vascular

Cardiovascular

GI

Musculoskeletal

PHYSICAL EXAM

Temp.

Pulse

BP

HT.

Weight

Respiration

GENERAL APPEARANCE

	N	AB	NOTES
Skin			
Head			
Eyes			
Ears			
Nose			
Neck			
Throat			
Chest			
Mouth			
Heart			
Breasts			
Lungs / Pulmonary			
Abdomen			
Genital			
Pelvic			
Rectal			
Extremities			
Neurological			
Emotional			

CLINICAL IMPRESSIONS

PLANS